IPDR6702				NORTH CAROLINA		PAGE:	1	
RUN DATE:	01/21/2008			CHECKWRITE SUMMARY REPORT				
				CKWRITE DATE: 01/24/2008 FINANCIAL PAYER: NCDMH				
				FIRMULAN PRINCE WORK				
PROVIDER		HIGH DENIAL	NUMBER OF		mira	momar	TOTAL	TOTAL
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	TNC	TOTAL	CLAIMS FINALIZED	CLAIMS PAID
3404901		8800	5	FURTHER PROCESSING NECESSARY.				
3404901	SMOKY MOUNTAINM H/DD/SAS	8800	5	PLEASE CHECK FOR CLAIM ON				
	III/ DD/ GAD			FUTURE RA'S.				
		8534	3	SERVICE FACILITY LOCATION IS N				
				OT A VALID IPRS ATTENDING		11	11	
				PROVIDER. PLEASE VERIFY THE F				
		8532	1	SUBMITTED BILLING PROVIDER IS				
				NOT ELIGIBLE FOR DATE OF				
				SERVICE BILLED				
3404904	WESTERN HIGHLAN	8505	770	CLAIM DENIED DUE TO INSUFFICIE				
	DS LME			NT BUDGET				
						-		
		8534	22	SERVICE FACILITY LOCATION IS N	0	853	7200	6347
				OT A VALID IPRS ATTENDING PROVIDER. PLEASE VERIFY THE F				
				THE P				
		191	18	CLIENT ID NUMBER DOES NOT MATC				
	ļ			H PATIENT NAME		<u> </u>		
3404910	PATHWAYS	8505	190	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET				
				NI BUDGET		ļ		
		8800	70	FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON		348	4617	4269
				FUTURE RA'S.				
		8599	32	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
2404010		0063	000	ACCURATION AND ADDRESS OF THE PARTY OF THE P				
3404912	CATAWBA COUNTYM ENTAL HEALT	8963	287	ATTENDING PROVIDER NPI IS NOT NUMERIC. PLEASE RESUBMIT				
	INTRO HEADT			WITH CORRECT NPI NUMBER.				
		8534	215	SERVICE FACILITY LOCATION IS N				
		0334	213	OT A VALID IPRS ATTENDING	0	679	4261	3582
				PROVIDER. PLEASE VERIFY THE F				
		8599	45	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
3404913	MECKLENBURG COM	8505	3213	CLAIM DENIED DUE TO INSUFFICIE				
	ENTAL HEALT			NT BUDGET				
	l	8326	3108	ATTENDING PROVIDER NUMBER WAS		6914	6988	74
				NOT SUBMITTED ON THIS CLAIM OR THE NPI SUBMITTE				
	ļ			THIS CLAIM OR THE NPI SUBMITTE		ļ		
		8800	222	FURTHER PROCESSING NECESSARY,				
				PLEASE CHECK FOR CLAIM ON				
				PUTURE RA'S.		-		
3404916	CROSSROADS BEHA	8534	1	SERVICE FACILITY LOCATION IS N				
	VIORAL HEAL			OT A VALID IPRS ATTENDING PROVIDER. PLEASE VERIFY THE F				
				THE P				
		0	0			1	1	0
	-					ļ		
3404917	CENTERPOINT HUM	3412	982	PROVIDER TYPE AND SPECIALTY 07		l		
	AN SERVICES			4/113 CANNOT BILL ENHANCED				
				BENEFIT SERVICES ON OR AFTER D		-		
		8505	280	CLAIM DENIED DUE TO INSUFFICIE	0	1450	2278	828
				NT BUDGET				
		11	127	CLIENT NOT ELIGIBLE ON SERVICE				
	ļ			DATE		ļ		
3404919	GUILFORD CO MEN	8505	3501	CLAIM DENIED DUE TO INSUFFICIE				
	TAL HEALTHC			NI BUDGET		l		
		8800	168	FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON		3925	3953	28
	-			PLEASE CHECK FOR CLAIM ON FUTURE RA'S.		 		
		8508	109	CLAIM DENIED NO BUDGET FOUND		ļ		
		1	l	<u> </u>		l		

PROVIDER NUMBER	1			I			momay	momar
NUMBER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	TOTAL	TOTAL
	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404920	ALAMANCE CASWEL	0	0	*** NO DATA TO REPORT ***				
	L AREA MH D							
	1							
		0	0		0	0	0	0
3404921	ORANGE PERSON C	11	149	CLIENT NOT ELIGIBLE ON SERVICE				
	HATHAM AREA			DATE		ļ		
	 							
	†	8564	10	SERVICE EXCEEDS THE ALLOWABLE		186	1078	892
				OF ONE OCCURRENCE WITHIN AN				
				ELIGIBILITY PERIOD.				
		0004		ONLY 12 ANALOG ALLOHOD DED DAY				
	-	8654	7	ONLY 16 UNITS ALLOWED PER DAY WITHOUT PRIOR		ļ		
				APPROVAL. PLEASE CORRECT THE				
	1							
3404922	THE DURHAM CENT	8505	15510	CLAIM DENIED DUE TO INSUFFICIE				
	ER			NT BUDGET				
	ļ	0000	1500	DUDBURD PROGRATIVA MEGRACIANI				
		8800	1592	FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON	0	18608	19114	506
	+	 		FUTURE RA'S.	<u> </u>			
	1					l		
		537	1187	PROCEDURE IS NOT COVERED FOR T				
				HIS DATE OF SERVICE				
	ļ							
3404923	Datum doublest :	8505	747	CLAIM DENIED DUE TO INSUFFICIE	ļ	ļ		
	FIVE COUNTY MH	1.7		NT BUDGET	-	l		
	 	 	 		 			
		8508	492	CLAIM DENIED NO BUDGET FOUND		1523	1615	92
	4							
	-	-			-			
	ļ	8800	145	FURTHER PROCESSING NECESSARY,				
	 			PLEASE CHECK FOR CLAIM ON	-	-		
				FUTURE RA'S.				
3404925	SANDHILLS CENTE	8505	2373	CLAIM DENIED DUE TO INSUFFICIE				
	R FOR MH/DD			NT BUDGET				
	ļ					ļ		
		8508	557	CLAIM DENIED NO BUDGET FOUND		3331	3456	125
	 				· · · · · · ·	3331	3430	123
		8800	251	FURTHER PROCESSING NECESSARY,				
	ļ			PLEASE CHECK FOR CLAIM ON FUTURE RA'S.				
				FUTURE RA'S.				
3404926	SOUTHEASTERN RE	8599	82	DETAIL NOT COVERED BY COMBINAT		l		
	G MENTAL HL			ION OF RECIPIENT, PROVIDER AND				
	1			BENEFIT PACKAGE.				
	ļ	23	69	SERVICE REQUIRES PRIOR APPROVA		235	1340	1105
				L				
	+					l		
	 	11	38	CLIENT NOT ELIGIBLE ON SERVICE				
	1			DATE				
340405-	1		170	AT VENUE NOW DE VATEVE ON				
3404927	CUMBERLAND CO M	11	179	CLIENT NOT ELIGIBLE ON SERVICE DATE	-	-		
	HC				-	-		
	1					l		
		21	131	DUPLICATE OF CLAIM-SYSTEM	0	392	1575	1183
	 		ļ					
	 	8518	42	*CLAIM DENIED. SUBMITTED BEYO				
	+		<u> </u>	ND TIMELY FILING LIMIT	 			
				IN EFFECT FOR THIS FISCAL YEAR				
3404930	JOHNSTON COUNTY	8505	179	CLAIM DENIED DUE TO INSUFFICIE				
	MNTL HLTHC			NT BUDGET				
			-					-
		1		DIAGNOSIS OR SERVICE INVALID F	l	L	5053	
	+	10	180					4647
	-	10	80			406	5055	
		10	80	OR CLIENT AGE. VERIFY CID, DIAGNOSIS, PROCEDURE CODE FOR	0	406	3033	
			80	OR CLIENT AGE. VERIFY CID, DIAGNOSIS, PROCEDURE CODE FOR	0	406	3033	
		10 8599	71	OR CLIENT AGE. VERIPY CID, DIAGNOSIS, PROCEDURE CODE FOR DETAIL NOT COVERED BY COMBINAT	0	406	3033	
				OR CLIENT AGE. VERIFY CID, DIAGNOSIS, PROCEDURE CODE FOR DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND	0	406	3033	
				OR CLIENT AGE. VERIPY CID, DIAGNOSIS, PROCEDURE CODE FOR DETAIL NOT COVERED BY COMBINAT	0	406	3033	
3404021		8599		GR CLIENT AGE VERIFY CID, DIAGNOSIS, PROCEDURE CODE FOR DETAIL NOT COVERED BY COMBINAT LON OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	0	406	3033	
3404931	NAKE CO HUM SVC		71	OR CLIENT AGE, VERIFY CID. DIAGNOSIS, PROCEDURE COUR FOR DETAIL NOT COVERED BY COMBINAT LOW OF RECIPHRY, PROVIDER AND RENEFIT PACKAGE. FURTHER PROCESSING NECESSARY,	0	406	3033	
3404931	HAKE CO HUM SVC BILLING OF	8599	71	GR CLIENT AGE VERIFY CID, DIAGNOSIS, PROCEDURE CODE FOR DETAIL NOT COVERED BY COMBINAT LON OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	0	406		
3404931		8599	71	OR CLIENT AGE. VERIFY CID. DIAGNOSIS, PROCEDURE COGE FOR DETAIL NOT COVERED BY COMBINAT CON OF RECIPIENT, PROVIDER AND BENEY!T PACKAGE. FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON FUTURE RA'S.	0	406		
3404931		8599	71	GE CLIENT AGE VERIFY CID. DIAGNOSIS, PROCEDURE CODE FOR DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENETIT FACKAGE. FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON FUTURE RAYS. CLIENT ID NUMBER DOES NOT MATC	0	406	40	35
3404931		8599	71	OR CLIENT AGE. VERIFY CID. DIAGNOSIS, PROCEDURE COGE FOR DETAIL NOT COVERED BY COMBINAT CON OF RECIPIENT, PROVIDER AND BENEY!T PACKAGE. FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON FUTURE RA'S.	0			35
3404931		8599	71	GE CLIENT AGE VERIFY CID. DIAGNOSIS, PROCEDURE CODE FOR DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENETIT FACKAGE. FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON FUTURE RAYS. CLIENT ID NUMBER DOES NOT MATC	0			35
3404931		8599 8800	71	GE CLIENT AGE VERIFY CID DIAGNOSIS, PROCEDURE CODE FOR DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, REOVIDER AND BENEFIT PACKAGE. FURTHER PROCESSING NECESSARY, FLEASE CHECK FOR CLAIM ON FUTURE RA'S. CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME	0			35
3404931		8599	71	GE CLIENT AGE VERIFY CID. DIAGNOSIS, PROCEDURE CODE FOR DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENETIT FACKAGE. FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON FUTURE RAYS. CLIENT ID NUMBER DOES NOT MATC	0			35
3404931		8599 8800	71	GE CLIENT AGE VERIFY CID DIAGNOSIS, PROCEDURE CODE FOR DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, REOVIDER AND BENEFIT PACKAGE. FURTHER PROCESSING NECESSARY, FLEASE CHECK FOR CLAIM ON FUTURE RA'S. CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME	0			3

							TOTAL	TOTAL
PROVIDER NUMBER	PROGRAMM No.	HIGH DENIAL EOBS	NUMBER OF DENIALS	DESCRIPTION	TNC	TOTAL	CLAIMS	CLAIMS
	PROVIDER NAME				DENIALS	DENIALS	FINALIZED	PAID
3404933	SOUTHEASTERN CT	8505	1637	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET				
	R FOR MH/DD			NT BUDGET		ļ		
				CLIENT NOT ELIGIBLE ON SERVICE				
		11	141	DATE	0	1919	3569	1650
	-	8952	53	CLAIM DENIED DUE TO AGE RESTRI				
	<u> </u>			CTIONS FOR TARGET POPULATION				
	 							
3404934	ONSLOW CARTERET	8505	753	CLAIM DENIED DUE TO INSUFFICIE				
	BEHAV HEAL			NT BUDGET				
		8534	447	SERVICE FACILITY LOCATION IS N OT A VALID IPRS ATTENDING		1498	2193	695
	 		-	PROVIDER. PLEASE VERIFY THE F				
		8599	113	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
3404935	WAYNE CO MENTAL	0	0	*** NO DATA TO REPORT ***				
	HEALTH CTR							
		0	0		0		0	0
			<u> </u>					
3404936	THE BEACON CENT	0	0	*** NO DATA TO REPORT ***				
	ER							——
		0	0					
	+	0	0					0
3404937		8536	10	ATTENDING PROVIDER TYPE AND SP				
3404937	THE BEACON CENT ER	0350	10	ATTENDING PROVIDER TYPE AND SP ECIALTY COMBINATION IS NOT		-		
				VALID FOR SUBMITTED BILLING PR				
	-	8599	6	DETAIL NOT COVERED BY COMBINAT	0	20	1447	1427
				ION OF RECIPIENT, PROVIDER AND				
	ļ			BENEFIT PACKAGE.				
		191	4	CLIENT ID NUMBER DOES NOT MATC				
	ļ			H PATIENT NAME				
3404939	EAST CAROLINA B EHAVIORAL H	8505	1447	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET				
	IIIAVIOIGII II							
		8800	144	FURTHER PROCESSING NECESSARY,		1825	2737	912
				PLEASE CHECK FOR CLAIM ON		1023	2/3/	912
				FUTURE RA'S.				
		120	71	CLIENT ID NUMBER MISSING OR IN				
				VALID. ENTER CID AND SUBMIT AS A NEW CLAIM				
	 							
3404941	EAST CAROLINA B	0	0	*** NO DATA TO REPORT ***				
	EHAVIORAL H							
		0	0					
	1					0	0	0
3404942				AAA VO DAWN TO DEPOSIT AAA				
3404942	EAST CAROLINA B EHAVIORAL H	0	0	*** NO DATA TO REPORT ***				
	-	0	0		n	0	0	0
						ļ		
3404943	ALBEMARLE MENTA	3411	123	PROVIDER TYPE AND SPECIALTY 07				
	L HEALTH CE			4/113 CANNOT BILL ENHANCED				
	 			BENEFIT SERVICES ON OR AFTER D		-		
		191	10	CLIENT ID NUMBER DOES NOT MATC		170	2599	2429
				H PATIENT NAME		l		\vdash
	 	8534	8	SERVICE FACILITY LOCATION IS N OT A VALID IPRS ATTENDING		ļ		<u> </u>
				PROVIDER. PLEASE VERIFY THE F				
3404944	EASTPOINTE HUMA	8533	61	SERVICE FACILITY LOCATION CANN				
	N SERVICES			OT BE AN ATTENDING PROVIDER				
				IDENTIFIED AS AN INDIVIDUAL.				
	<u> </u>	8536	22	ATTENDING PROVIDER TYPE AND SP	0	130	1270	1140
				ECIALTY COMBINATION IS NOT VALID FOR SUBMITTED BILLING PR				
	<u></u>		<u></u>					
		8599	20	DETAIL NOT COVERED BY COMBINAT				
	 			ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.		l		
24042			100					
3404946	FOOTHILLS AREAM ENTAL HEALT	21	100	DUPLICATE OF CLAIM-SYSTEM				
		8534	90	SERVICE FACILITY LOCATION IS N		273	2093	1820
				OT A VALID IPRS ATTENDING	0	2/3	2093	1820
				PROVIDER. PLEASE VERIFY THE F				
	+	8599	36	DETAIL NOT COVERED BY COMBINAT				
	I		I	ION OF RECIPIENT, PROVIDER AND				

		BENEFIT PACKAGE.		